Basic Health™

Frequently Asked Questions

Information to help you complete your Basic Health application

Thank you for your interest in Basic Health. Enclosed you will find:

- A Basic Health application with a return envelope.
- *Understanding Basic Health*, with information on eligibility, benefits, coverage, and health plans.
- *Health Plans and Premiums*, to find health plans in your area, and help figure your monthly premium.
- A *Resource List for Basic Health*, with information on who to contact in your area for application assistance.

What do I need to send with my application?

Along with your **signed and completed application**, you need to provide proof of your address and income, and a copy of your federal income tax return from the most recent tax year.

Proof of Washington State residency

Send a copy of a document showing your name and current street address. Examples include:

- Your current utility bill showing physical address
- Washington State driver license or ID card
- Rent or mortgage receipt
- Current school registration

Documents only showing a post office box are not proof of your street address. If you live with someone else, you must provide proof of that person's street address and a signed statement from the individual saying you live there.

Proof of income

You must complete Section 7 of the application. **Page 5 of the application explains the types of documents to send in most situations.** Here are a few additional tips:

- **A copy of one of the following showing proof of your income for last year:**
  - Your IRS Form 1040 (federal income tax return) and all Schedules filed.
  - IRS transcript of your 1040, if you do not have a copy of your IRS Form 1040.
  - Letter from the IRS if you did not file a tax return (non-filing status).

  To request a transcript or letter of non-filing status, call the IRS at 1-800-829-1040. If you have questions or cannot get documents from the IRS, call us at 1-800-660-9840.

What do I need to send with my application?

(continued from page 1)

- **Zero income** – If you or your spouse received no income or benefits in the last 30 days, complete the statement on the *Family Income Reporting Form* (page 4 of the enclosed Basic Health Application).
- **Self-employment** – If you or your spouse are self-employed or have rental income, send a copy of all business forms and Schedules filed with the IRS, and your Schedule(s) K-1 (if applicable).

  You must complete and send the *Self-Employment or Rental Income Reporting Form (Form A)* in Section 7 if you:
  - Did not file a federal tax return; **or**
  - Have been in business for less than 12 months.

  If you have been in business for more than 12 months, but did not file a tax return, you must complete 12 months' worth of income information on the worksheet.
- **Employer or sponsor account** – If your employer/sponsor is paying part or all of your premium, return your completed application to their representative. Do **not** send money with your application.

Please respond right away to requests for additional information; otherwise, you may be required to reapply for Basic Health.

Is there space available in Basic Health?

Basic Health can only enroll a limited number of people. Applications are processed on a first-come, first-served basis. If Basic Health is full, you may have to wait for space to become available. **Coverage is offered once you are found eligible and space is available.** You will be notified if your coverage will be delayed.

What is the Maternity Benefits Program?

Any woman who is pregnant when she applies for Basic Health will be enrolled in and receive benefits through the DSHS Maternity Benefits Program, if eligible for that program. Maternity Benefits Program coverage is free, and there are no copayments for services or prescriptions. See *Understanding Basic Health* for details.

Who should I list as my dependents?

On the application, Section 4, list:

- Your unmarried children, who are:
  - Under age 19, including your stepchildren, legally adopted children, or other children for whom you have legal guardianship (you must provide proof of legal guardianship); **or**
  - Under age 19, enrolling for coverage, and in your custody under an informal guardianship agreement signed by the child's parent(s) and authorizes you to obtain medical care for the child. You must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support; **or**
  - Under age 23, including your stepchildren, legally adopted children, or other children for whom you have legal guardianship (you must provide documentation of legal guardianship), and a full-time student in an accredited school (you must provide proof of full-time student status); **or**
- Your dependent of any age who is incapable of self-support due to disability. You must provide proof of disability and, if the disabled dependent is not your natural or adopted child, proof of legal guardianship.

Can I deduct child care expenses from my income?

Yes, if your dependent spends time in dependent care so the adults in the home can go to work or school. You must provide copies of your receipts that show the amount you paid, and the child care provider's name, address, and phone number (cannot be a parent or stepparent of the child or another of your dependents). If you are a student, send proof of enrollment from the school.

What if I'm sick or hurt before my coverage starts?

Basic Health will not pay for treatment until your coverage begins. Also, you may have a waiting period for pre-existing conditions even after your Basic Health coverage begins. See *Understanding Basic Health* for details.

Prescription drugs are not subject to a waiting period.

There are no waiting periods for pre-existing conditions for members of Basic Health *Plus* or the Maternity Benefits Program. Also, when applying for these programs, you may request help with unpaid medical bills for the last three months by answering "yes" to the appropriate question in Section 3.

Are dental and vision covered under Basic Health?

Basic Health does not cover dental or vision services. Dental and vision are available to members enrolled in Basic Health *Plus* and the Maternity Benefits Program.

What's next?

We review applications on a first-come, first-served basis. If additional information or documents are needed, we will send a letter asking for this information. Please note that requests for additional information will delay your enrollment, so include all information when you send in your application. If you are found eligible for Basic Health and space is available, you will receive an offer of enrollment and a bill for your first month's premium. Once enrolled, you will receive confirmation from Basic Health and your health plan. Your health plan will send your ID card and list of providers within the first 15 days of coverage.

Once you are enrolled, you will receive a *Basic Health Member Handbook*, which gives all the details of your Basic Health coverage.

If we delay your enrollment because Basic Health is full, and you submitted payment for coverage when you applied, Basic Health will notify you of the delay and refund your payment.

Helpful hints:

- **Use the checklist at the end of the application to make sure you have sent all necessary documentation with your application.**
- List all family members on the application even if you do not want coverage for them. Family members **do not** include girlfriends or boyfriends living in your home.
- If you want Basic Health *Plus* coverage for a child listed on your application, and the other biological parent of that child is living with you, send proof of that parent's gross income for the last 30-day period. Please be sure to list this parent in Section 5 of the application.
- Include birth dates for everyone listed on the application. Also, Social Security numbers **are required** for children enrolling in Basic Health *Plus* and for women applying for the Maternity Benefits Program.

Free coverage for kids!

Your children under age 19 may be eligible for free health coverage through Basic Health *Plus*.
All of the information needed to apply is enclosed.

What is Basic Health *Plus*?

Basic Health *Plus* is a Basic Health and Department of Social and Health Services (DSHS) program. Your children will get care through the same health plan as other family members on Basic Health. There are no premiums, no deductibles, and no copayments.

In addition to the services your health plan provides, Basic Health *Plus* includes:

- Dental care
- Vision care
- Hearing care
- Physical therapy services

How do I enroll my children?

When you complete the Basic Health application, indicate in Section 3 whether you are applying for Basic Health *Plus* for anyone in your family. You will also need to answer "yes" to "Applying for Basic Health *Plus* coverage?" for the appropriate dependents in Section 4. DSHS will notify you once they have processed your application.

Is your family income higher than BH eligibilty guidelines and you are looking for coverage for your children? You can call 1-877-KIDS-NOW (1-877-543-7669) or visit the website **www.parenthelp123.org** to find out if your children may be eligibile for medical, dental and vision coverage. The cost is $15 a month per child with maximum out of pocket expense of $45 a month for a family.

Total number in your family	Gross Monthly income limit for low-cost coverage
1	$2,167
2	$2,917
3	3,667
4	4,417

Add $750 for each additional family member. For questions or additional information about the program call: 1-877-KIDS-NOW.

Questions?

Please call Basic Health at 1-800-660-9840.

Basic Health™

Washington State Department of Social & Health Services

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.
한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

FOR OFFICE USE ONLY

Basic Health™ Application

NOTE: ***Use blue or black ink to complete this application. Your Social Security number (SSN) is voluntary, unless you answer "yes" to any of the questions in Section 3. If you do not provide your SSN, we will assign an ID number to you. We depend on your SSN for verifying income with certain sources. If you do not provide your SSN, you will have to prove your eligibility for Basic Health more often.***

Section 1: APPLICANT AND HOUSEHOLD INFORMATION

*What language **and dialect** do you speak?* _____ *Check here if you need an interpreter:* ❑

Applicant's last name	First name	MI

Street address required; **must attach proof** Apt. #	City	County	State	ZIP Code
Mailing address or P.O. box (if different from above)	City		State	ZIP Code

Home phone number ( ) Other phone number ( )

Marital status (check one): ❑ Single ❑ Legally separated ❑ Legally married - Date of marriage: _____

E-mail address

Do you have Internet access? ❑ Yes ❑ No

Section 2: COVERAGE FOR APPLICANT AND SPOUSE

*Complete this section for applicant and legal spouse, **even if not** requesting coverage.*

	Social Security number	Birth date	Gender	Requesting coverage?	U.S. citizen?	Receiving DSHS benefits?
For applicant listed above →			❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Spouse's last name, first name, MI	Social Security number	Birth date	❑ Male ❑ Female	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Are you or a family member currently receiving Social Security disability benefits (SSDB)? ❑ Yes ❑ No
***If "yes,"** list them here with dates benefits started. Attach copies of the original and current award letters for each.*

Name: _____ SSDB entitlement date: _____

Name: _____ SSDB entitlement date: _____

Are you or a family member eligible for Medicare (the federal health program for people over age 65 or people who have been receiving Social Security disability benefits for more than two years)? ❑ Yes ❑ No
***If "yes,"** list them here:*

Name: _____ SSDB entitlement date: _____

Name: _____ SSDB entitlement date: _____

Was anyone on this application a member of the Washington National Guard or Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle? ❑ Yes ❑ No ***If yes,** send a copy of Form DD214 for priority enrollment.*

Are you or a family member attending school full time in the United States on a temporary student visa? ❑ Yes ❑ No
***If "yes,"** list them here:* _____

Section 3: HEALTH PLAN SELECTION AND ADDITIONAL PROGRAM CHOICES

CHOOSE ONE HEALTH PLAN FOR YOUR FAMILY

Not all health plans are available in every county. Read the *Health Plans and Premiums* brochure to see the plans available where you live.

CHECK ONE

- ❑ **Columbia United Providers, Inc.**
- ❑ **Community Health Plan of Washington**
- ❑ **Group Health Cooperative**
- ❑ **Kaiser Permanente**
- ❑ **Molina Healthcare of Washington, Inc.**

Refer to Understanding Basic Health *for details on the services provided by those programs.*

ARE YOU APPLYING FOR:

- Basic Health *Plus* for a family member under 19 on this application? ❑ Yes ❑ No
- Basic Health *Plus* for a child with an urgent medical need? ❑ Yes ❑ No
- Coverage for someone who is currently pregnant? ❑ Yes ❑ No
  If "yes," has she received a positive result from a pregnancy test? ❑ Yes ❑ No
  Expected date of delivery: _____ Place of birth: City/State _____
  Pregnant woman's name (print): _____
  Pregnant women's signature: _____
- Basic Health *Plus* or the Maternity Benefits Program, and want to be referred to DSHS for help with unpaid medical bills from the last three months? ❑ Yes ❑ No
  ***If yes,** attach proof of income for those three months.*

Social Security numbers are required if you answered "yes" to any of these questions.

TYPE OF COVERAGE (CHECK ONE):

❑ Individual/family coverage **OR**

❑ Coverage through an employer, home care agency, or financial sponsor *(Complete the information below, and submit your completed application through your organization's contact. DO NOT send your application materials directly to Basic Health.)*

Employer/organization _____ Group ID number _____ Daytime phone number ( ) _____

◀ Please detach at perforation. ◀

Section 4: LEGAL DEPENDENTS *(If more than four, list on a separate sheet or copy this page.)*

List all of your legal dependents, *even if you do not want coverage for them or they are not living in your home. Do not list foster children. Dependents ages 19-22 must be enrolled full time in an accredited school (proof from school must be included) or have a documented disability to be listed on your application. (Refer to* Understanding Basic Health *for more information.)*

1 Last name, first name, MI		Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Social Security number
Place of birth: City/State			Birth date
Gender: ❑ Male ❑ Female	Applying for Basic Health?* ❑ Yes ❑ No	Applying for Basic Health *Plus*?* ❑ Yes ❑ No	Is dependent, age 19-22, a full-time student? ❑ Yes ❑ No If yes, send proof of registration.
Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	Does dependent have a disability? ❑ Yes ❑ No

2 Last name, first name, MI		Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Social Security number
Place of birth: City/State			Birth date
Gender: ❑ Male ❑ Female	Applying for Basic Health?* ❑ Yes ❑ No	Applying for Basic Health *Plus*?* ❑ Yes ❑ No	Is dependent, age 19-22, a full-time student? ❑ Yes ❑ No If yes, send proof of registration.
Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	Does dependent have a disability? ❑ Yes ❑ No

3 Last name, first name, MI		Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Social Security number
Place of birth: City/State			Birth date
Gender: ❑ Male ❑ Female	Applying for Basic Health?* ❑ Yes ❑ No	Applying for Basic Health *Plus*?* ❑ Yes ❑ No	Is dependent, age 19-22, a full-time student? ❑ Yes ❑ No If yes, send proof of registration.
Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	Does dependent have a disability? ❑ Yes ❑ No

4 Last name, first name, MI		Relationship to applicant ❑ Son ❑ Daughter ❑ Other:_____	Social Security number
Place of birth: City/State			Birth date
Gender: ❑ Male ❑ Female	Applying for Basic Health?* ❑ Yes ❑ No	Applying for Basic Health *Plus*?* ❑ Yes ❑ No	Is dependent, age 19-22, a full-time student? ❑ Yes ❑ No If yes, send proof of registration.
Is dependent a U.S. citizen? ❑ Yes ❑ No	Is dependent receiving DSHS medical assistance? ❑ Yes ❑ No	Is dependent living in the home full-time? ❑ Yes ❑ No	Does dependent have a disability? ❑ Yes ❑ No

*You may check "yes" to apply for both Basic Health and Basic Health *Plus* for children. If you are eligible and ask for both regular Basic Health and Basic Health *Plus*, we will offer regular Basic Health while your eligibility for Basic Health *Plus* is under DSHS review.

If you are applying for any dependents who don't live in your home full time, ***complete the following for those dependents.***

Dependent's name	Address	City	County	State	ZIP Code

Do you pay court-ordered child support? ❑ Yes ❑ No If yes, how much per month do you pay? $_____
(This may help you qualify for Basic Health *Plus* or the Maternity Benefits Program.)

If you checked "no" to "U.S. citizen" for any family member applying for Basic Health *Plus* or the Maternity Benefits Program***, please send a copy (front and back) of that person's U.S. Citizenship and Immigration Services (USCIS) documentation, and indicate the date of arrival into the United States:***_____

If any of your dependents (age 19 or over) are disabled or otherwise under your legal guardianship, ***attach a copy of legal guardianship papers.*** If your dependent child (through birth or adoption) has a disability, you only need to provide proof that he or she cannot support himself or herself due to disability.

Section 5: OTHER BIOLOGICAL PARENT (IF LIVING IN THE HOME)

Are you applying for Basic Health *Plus* coverage for a dependent whose other biological parent is not legally married to you, but is living in your home? (This information is used to determine Basic Health *Plus* eligibility only. If the other biological parent wants Basic Health coverage, he or she must submit a separate application.)

❑ Yes ❑ No

If you checked "yes," *you must fill in the following information about that parent.*
Attach proof of this person's income.

Name of other biological parent	Social Security number (required	Birth date	Gross monthly income (before taxes)	Daytime phone number ( )
Employer/company name	Employer's address			Employer's phone number ( )

List the names of this parent's children shown on your application:

_____ _____

_____ _____

Section 6: OTHER HEALTH INSURANCE INFORMATION

List yourself and any family members who have other health insurance or are covered under a health program (such as Tri-Care, Medicare, or Medicaid), even if they're not applying for Basic Health coverage. If you need more room, use a separate sheet and include your full name and address.

Last Name, first name, MI (List yourself first.)	Health insurance company or health program	Phone number of health insurance company or health program	Policy or group number	Policy end date
		( )		
		( )		

◀ Please detach at perforation. ◀

Section 7: FAMILY INCOME

Fill in the following information for all current employers for yourself and your spouse, if legally married. If you need more room, use a separate sheet and include your full name and address.

	Applicant	Spouse
Employer/company name		
Employer's address		
Employer's phone number		
Date you started working for this employer		
Employer/company name		
Employer's address		
Employer's phone number		
Date you started working for this employer		

Section 7: FAMILY INCOME (continued)

Family Income Reporting Form

Show gross amounts (before taxes) on this form.

Have you changed employers in the last 12 months? ❑ Yes ❑ No Has your income changed in the last 12 months? ❑ Yes ❑ No

Briefly explain change(s) _____

_____

If you have not received a full 30 current/consecutive days of income or benefits from any source of income you listed above, please explain why here. Also explain any periods for which you don't have documentation.

_____

_____

_____

_____

Basic Health may average or use your last 30 days' income to get the most accurate picture of your income.

You **must** check "yes" or "no" for each family member on every income line item. Show gross monthly amounts. If more dependents, list on a separate sheet or copy this form.	Self	Spouse	Child
Gross wages, salary, tips, assistantships, commissions	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	
Self-employment or rental income Provide Washington State Unified Business Identifier (UBI) # _____ Check box if no UBI # ❑ (For details on what to send Basic Health, see the next page.)	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Unemployment compensation, strike benefits	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	
Social Security benefits - circle types received Retirement Survivor Supplemental security (SSI) Disability If Social Security disability, date of entitlement _____	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Retirements, pensions, annuity benefits Is the amount received due to an early withdrawal? ❑ Yes ❑ No	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Child support, alimony/spousal maintenance received	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Insurance benefits, whether private or through employment, such as life, accident, long- or short-term disability	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Veterans benefits, military allotments	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Workers' compensation	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Public assistance cash grants **DO NOT INCLUDE FOOD STAMPS**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Income from any other source Explain _____ _____ _____	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**
Work- or school-related dependent/child care expenses	❑ Yes ❑ No **$**	❑ Yes ❑ No **$**	

▶ Please detach at perforation. ▶

Explanation of income types and what to send with your *Family Income Reporting Form*

You must provide proof from the Internal Revenue Service (IRS) of the following:

- Your IRS Form 1040, federal income tax form, and all schedules
- Schedule K-1 for each family member for each S-Corporation, partnership, or trust beneficiary
- A complete IRS transcript, if you do not have a copy of your IRS Form 1040
- Verification of non-filing status from the IRS if you did not file a tax return

To request a transcript or letter of non-filing status, call the IRS at 1-800-829-1040.

Proof of income must include the name of the person paid, the **gross** amount(s) paid, and the dates paid. Send a full 30 days' proof for each income source. On a separate sheet, explain any gaps in income. **(Always send current documents.)** If you need another copy of this form, or would like more information about Basic Health, visit our Web site (**www.basichealth.hca.wa.gov**).

Do not mail originals to Basic Health; they will not be returned to you.

Explanation of income type	Examples of copies you might send
Wages, salary, tips, assistantships, commissions	• Pay stubs for four consecutive weeks or one month • Signed and dated statement from employer(s)
Self-employment or rental income	• IRS 1040 and all applicable schedules • Schedule K-1(s), if applicable • Statement of income and expenses (any business not shown on 1040) • Washington State Unified Business Identifier (UBI) number
Unemployment compensation, strike benefits	• Unemployment stubs for four consecutive weeks or one month • Strike benefit statement • Computer print-out from agency/payer
Social Security benefits	• Initial notice of award letter • Statement showing monthly benefit amount • Computer print-out from agency/payer
Retirements, pensions, annuity benefits	• Award letter or benefit statement • Cost of living allotment statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer
Child support, alimony/spousal maintenance	• Payment order • Court documents or Division of Child Support (DCS) statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer • Copy of check or signed statement from recipient
Insurance benefits	• Award letter • Court documents • Statement from institution
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	• IRS 1040 and all applicable schedules • Statement from trustee, investment firm, bank, or financial institution • Court documents • Copy of contract
Veterans' benefits, military allotments	• Award letter or benefit statement • Leave and Earnings Statement (LES)
Workers' compensation	• Award letter or benefit statement • Labor & Industries (L & I) payment order for four consecutive weeks (two consecutive orders)
Public assistance cash grants	• Award letter or benefit statement • Computer print-out from Department of Social and Health Services (DSHS)
Income from any other source	• Signed and dated statement from payer • Signed and dated statement from applicant/member
Personal care workers, independent providers	• Social Service Payment System (SSPS) invoice, **and** • Remittance Advice, pages 1 and 2

Can dependent care expenses be deducted?

Yes; you may deduct work- or school-related dependent care expenses (work- or school-related means the dependent spends time in dependent care so that adults in the home can go to work or school). You must provide copies of receipts that include the amount you paid, the dates of care, and the dependent care provider's name, address, and phone number.

◀ Please detach at perforation. ◀

Section 7: FAMILY INCOME (continued)

FORM A: Self-Employment or Rental Income Reporting Form

Name_____ Basic Health ID #:_____

Mailing Address: _____

If you filed an income tax return for your business, provide a copy of all forms, schedules, and K-1s, if applicable. If you have more than one business, copy this form, or print from our Website (**www.basichealth.hca.wa.gov**). Complete a separate form for each business.

If you have owned the business(es) or rental property less than 12 months and it's not reported on your Schedule C, fill in the income and expenses for the number of months you have been in business or owned the property.

Do not mail originals to Basic Health; they will not be returned to you.

Name of business					
Name(s) of business owner(s)					
Washington State Unified Business Identifier (UBI) #				Check box if no UBI # ❑	
Date business began / /	**Months you are reporting** From / / through / /			Total number of months in business	
Type of business	❑ Rental(s) ❑ Sole proprietor	❑ C-Corporation ❑ S-Corporation	❑ LLC ❑ Partnership	Percent of business owned by you and your spouse, if married	%

Income	**Total for this period**
Gross receipts, sales, or rental income	

Expenses: Business-related only **(Basic Health does not allow depreciation or amortization)**	**Total for this period**
Merchandise and materials	
Gross wages paid to employees (less employment credits)	
Employer's payroll-related taxes	
Advertising/other promotional	
Car and truck	
Commissions/management fees	
Insurance (not Basic Health)	
Interest—Mortgage	
Interest—Other	
Legal and professional fees	
Rent or lease of vehicles, machinery, equipment	
Rent or lease of other business property	
Repairs and maintenance	
Supplies	
Taxes and licenses	
Travel, meals, and entertainment	
Utilities	
Business use of the home (If you can prove more than half of your home is used for business most of the year, or you have a separate building on your residential property that is used only for business)	
Total business expenses	
Total net profit (or loss)	

▶ Please detach at perforation. ▶

Section 8: VOLUNTARY INFORMATION

Completing this section is voluntary and will not affect your ability to enroll, but may help us to better assist you.

ETHNIC BACKGROUND

- ❑ Black/African-American
- ❑ White/Caucasian
- ❑ Indian (Native American)
- ❑ Eskimo
- ❑ Aleutian Islander/Aleut
- ❑ Asian or Pacific Islander (API)
- ❑ Hispanic/Latin American
- ❑ Other or mixed ethnic background

WHERE DID YOU GET YOUR APPLICATION?

- ❑ Family/friend
- ❑ Local, nonprofit organization
- ❑ Website
- ❑ Medical office/hospital/clinic
- ❑ Government office, such as DSHS or health department
- ❑ Called Basic Health and received it by mail
- ❑ Other

WHERE DID YOU HEAR ABOUT BASIC HEALTH?

- ❑ Family/Friend ❑ Website
- ❑ Government Office: _____
- ❑ Local, non-profit organization: _____
- ❑ Medical office/hospital/clinic: _____
- ❑ Other: _____

Section 9: PERMISSION FORM (optional)

If you want someone else to be given information about your Basic Health acccount, or help with your application of future changes to your account, please complete, sign, and date this form.

This form is for Basic Health only. It will not be used for medical information, Basic Health *Plus*, the Maternity Benefits Program, or your health plan.

This permission will be in effect until you leave Basic Health or tell us to cancel it.

◀ Please detach at perforation. ◀

To: Basic Health

The person(s) named below are authorized to act as my or my family's representative(s) in the preparation and submission of the Basic Health application and future changes to my Basic Health account.

The person(s) listed below may provide information necessary for processing my application, enrollment, and future changes to my Basic Health account.

I understand that by signing this form I have not authorized the release or sharing of my health information.

This permission will continue as long as I am enrolled in Basic Health unless I notify Basic Health that it is cancelled.

Applicant's name (please print): _____

Name(s) of person(s) / representative(s) given permission to access account:	Relationship to applicant OR name of organization (list phone or fax number):
_____	_____
_____	_____
_____	_____

Must be signed by you and your spouse (if applicable)

X _____ _____
Your signature Date

X _____ _____
Your signature Date

Signature of all children age 18 and over who are applying for Basic Health coverage

X _____ _____
Your signature Date

X _____ _____
Your signature Date

Washington State law may require disclosure of any information you submit as a public record. Basic Health is administered by the Health Care Authority. Our Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Section 10: AGREEMENT AND SIGNATURE

I understand that:

- I must provide proof of my family's gross income (before taxes and deductions) and report income changes that would change my premium or eligibility to Basic Health/Department of Social and Health Services (DSHS) within 30 days after the end of the month my income changed.
- By signing this form, I have authorized Basic Health and DSHS to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family. I must report, for example, my marriage or divorce, or the marriage or divorce of any family member on my account, the birth or adoption of a child, or the date when a child leaves home or is no longer a dependent or is no longer a full-time student.
- My application and the documents I send to Basic Health will be used to determine eligibility for DSHS programs (Basic Health *Plus* or the Maternity Benefits Program) according to DSHS program requirements.
- By asking for and receiving DSHS benefits, my family and I assign to the state of Washington our rights to any third-party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health/DSHS programs.

I have read and I understand the information provided to me with the Basic Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Basic Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my family or I may lose coverage, may be held financially responsible for services obtained under Basic Health or additional or past premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

AGREEMENT MUST BE SIGNED BY YOU AND YOUR SPOUSE, IF LEGALLY MARRIED

X _____ Signature of applicant	_____ Date	X _____ Signature of spouse	_____ Date

Signature of all dependents age 18 and over

X _____ Signature	_____ Date	X _____ Signature	_____ Date
X _____ Signature	_____ Date	X _____ Signature	_____ Date

▲ Please detach at perforation. ▲

Use this checklist below to make sure you include:

- ❑ Documentation of full 30 days' income from all sources.
- ❑ Current tax year 1040 form, including all schedules and K-1 form, if you received one, or proof of nonfiling if not required to file. If you did not file a Form 1040, call the Internal Revenue Service and ask for a letter of nonfiling status.
- ❑ Documents showing your name and current street address.
- ❑ Court order showing required child support you are paying, if applying for Basic Health *Plus* or the Maternity Benefits Program.
- ❑ Application signed by all family members over age 18.
- ❑ Your health plan choice on the first page of this application.
- ❑ The Permission Form (included in this packet), if you'd like someone else to be able to access your account information.

Please submit all required forms and documentation.

Mail to: Basic Health, P.O. Box 94213, Seattle WA 98124-6513
FAX: 360-923-2910

Questions? Call 1-800-660-9840
On the Internet, go to: www.basichealth.hca.wa.gov

Basic Health™

Washington State Department of Social & Health Services

Privacy statement: We will keep your information private as allowed by law. The Washington State Health Care Authority runs Basic Health. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov**.